What’s wrong with the NHI Bill Let us count the ways –
Business Day 11 September 2019

NHI contributions would be based on income, this would necessitate those 2.1-million South Africans each paying in an additional R11,202 per month

A lot of commentary has been delivered in the last two weeks, since the National Health Insurance (NHI) Bill was introduced to parliament on August 8, covering its ramifications for the health industry and the country at large. But we also need to focus on what is not stated in the bill, as it is here that the bill’s implementation will really be tested.

To begin with, this bill needs to be placed in context. Historically, since the 1920s, SA, with its rich history of proposals for reforming healthcare and social security systems, has conducted more than 10 such reviews, including Collie’s committee of inquiry into NHI in 1941, the Freedom Charter in 1955 and the Taylor committee of inquiry in 2002, to name but a few. This latest edition is therefore not the first time an attempt has been made to come up with a revised system that will benefit all citizens.

However, first we have to acknowledge that SA’s fiscus is stretched, and that the only workable proposal for funding an NHI system is to use tax revenue. According to the National Treasury, we have 7.6-million taxpayers and according to Sars we have 4.8-million assessed taxpayers, who collectively pay about R1.2bn in taxes annually. But, the bulk of this tax revenue — some 82% — is drawn from only 2.1-million taxpayers.

According to Stats SA, the country has about 58.8-million people living in the country. Of those, 8.8-million pay for private medical cover, and the Council for Medical Schemes’ annual report shows that they pay a collective sum of R179.8bn a year, at an average contribution rate per member of R1,695.10 per month.

Funding requirements — two options

The intention of the NHI, on implementation in 2026, is to provide everyone living in SA the same type of cover in the public system as that enjoyed by those that can afford it in the private healthcare sector. This essentially leaves us with two options.

Option 1 guarantees everyone the same level of care as that experienced through private medical aid, which — using the figures given above — would create an NHI bill of R98.3bn per month, or R1.18-trillion per year.

Option 2, modeled on the most basic plan available from the largest open medical aid scheme, could involve restricting members to a network of healthcare facilities for hospitalisation — similar to the proposed central or accredited hospitals per the NHI Bill — and limiting medication to formularies, also in line with proposals within the bill.

The NHI Bill reveals that the chief funding for the system will be procured through general taxes, a re-allocation of tax credits and a payroll tax, calculated according to income levels

Considering the minimum premium available from the scheme for a main member and spouse would be R839 each, and R505 per child, and appreciating that these premiums are
applicable to the lowest earners earning up to R9,000 per month, we attempted to come up with an indication of costs.

The average SA family size is two adults and two children. This means that if we were to provide medical cover for 58.8-million people, then 29.4-million people would be main members and spouses, and the remaining 29.4-million people would be children. The very lowest premium for providing healthcare on the subsidised basis of scheme mentioned above, would come in at R474bn per year to cover health costs alone, assuming everyone earned less than R9,000, which is obviously not the case.

**Tax considerations for funding**

To put this in perspective, SA’s budgeted healthcare expenditure for 2017/2018 by the National Treasury was R191.7bn. The Treasury would require an increase in taxation revenue of R987.9bn for option 1 and an additional R282.3bn for option 2, which is the most basic level of medical cover available from the country’s largest open medical aid.

The NHI Bill reveals that the chief funding for the system will be procured through general taxes, a re-allocation of tax credits and a payroll tax, calculated according to income levels. If we consider that 82% of income tax is paid by 2.1-million individuals, and that the NHI contributions would be based on income, this would necessitate those 2.1-million South Africans each paying in an additional R134,428 annually, or R11,202 per month — and that’s just for option 2. By 2026, when the NHI is supposed to launch, these costs will have escalated significantly, since healthcare cost increases tend to outstrip inflation by 3% annually.

By way of the final benefits to be provided by NHI in return, details are scant. The bill does, however, confirm its purpose; outline its funding mechanisms; confirm which types of health establishments would be included; confirm who would be covered; how registration would take place; under which circumstances payment would be denied; and confirms the rights of registered users, among other particulars.

**Barriers to implementation**

The bill also covers milestones that need to be reached in the next phase until 2022, in setting up the fund and certifying health facilities, as well as the final phase to 2026. The bill does not yet deal sufficiently with barriers to implementation such as the new biometric system required or the extent and the sophistication required of the IT system that will track registration, provide electronic record-keeping and manage transferable records. All this will need to be processed in accordance with the Protection of Personal Information Act (POPI), ensuring the protection and safeguarding of personal confidential information within a system with multiple access points countrywide.

The bill doesn’t yet give sufficient consideration to the distances between clinics, hospitals and doctors in rural areas, nor does it provide sufficient answers to how we will address human resource limitations, particularly of qualified staff.

**Serious questions must be asked about existing medical aid premiums and the system’s affordability**
Of further concern is the continued — and often expedited — exodus of skills, following the release of a bill such as this, which provides very little information to existing service providers regarding NHI fee-setting into the future. Doctors are, right now, very concerned about increased patient numbers, chances of medical errors, malpractice suits and premiums, as well as their own ability to meet income goals and maintain standards of living.

**A greater divide between the ‘haves’ and ‘have-nots’**

All indicators point to a situation in which, contrary to the intention of the implementation of NHI, there is the possibility of an even greater divide between the “haves” and “have-nots”. Some people will insist on receiving private healthcare, and some doctors will not go through the accreditation process and will continue to fall outside the public system. Some hospitals may also opt to remain unaccredited so that there will remain parallel pathways to superior benefits.

A possible future scenario is a mandatory NHI tax premium for all taxpayers, while private medical aid remains available for private healthcare benefits, and individuals will selectively fall outside the NHI, widening the gap in the quality of healthcare on offer in the two systems.

Serious questions must be asked about existing medical aid premiums and the system’s affordability. What will happen to the average family of four’s medical aid premium, when, currently, the average family pays R6,780.40 for medical aid but will need to fund an additional R11,202 in tax per month to belong to NHI?

Employees who fall at the lower end of the income scale and have worked hard to obtain private medical cover may, once again, be forced to revert to the public system, increasing the burden on its facilities, which already cannot cope.

Right now there seem to be far too many gaps and unanswered questions which require serious attention before any further progress — and an intelligible opinion thereof — can be made on this contentious bill and its ramifications for every single South African.

* Larkan is head of healthcare consulting at GTC.